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W 000	INITIAL COMMENTS A recertification survey was conducted from March 17, 2010 through March 19, 2010. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a population of four female and two male clients with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and two day programs, interviews with staff, and the review of clinical and administrative records including incident reports.	W 00	4-19-2010 Received GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure outside services met the clients needs, of one client included in the sample. (Client #1) The findings include: I. The facility failed to ensure that staff working with Client #1 at her day program were using the recommended adaptive feeding equipment. During mealtime observations on March 17, 2010, at 7:30 a.m., 4:00 p.m., and 7:10 p.m., staff was observed putting spoonfuls of food on the Client #1's spoon and handing it to the client. The client was observed putting the food into her mouth, after verbal cueing. The client used a	W 120	The facility nurse reported to client #1's day program, and inserviced the staff on client #1's mealtime adaptive equipment, and mealtime protocol. 3-19-10 The day program was provided with all of client #1,s mealtime adaptive equipment. The facility nurse went to inserviice the day program staff again on 4-15-10 Refer to attachment #1. In the future, the facility management will ensure that client #1 uses similar mealtime adaptive equipment at the facility as well as at the day program; in addition, the QIDP is visiting the day program on an going basis during lunch time to ensure that client #1 is provided with the appropriate mealtime adaptive equipment..	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Edwards Program Director		4-19-10

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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W 120	Continued From page 1 right handled curved spoon, high side plate, dycem mat and nosey cup, to assist with her meal. Lunch observations were observed at Client #1's day program on March 17, 2010, at 12:50 p.m. The day program staff was observed feeding the client, using hand over hand techniques. An elevated plate riser, a regular plate, a built up hand spoon and a styrofoam cup were used during the meal. The plate was observed siding on the the elevated plate riser. Interview with the day program staff on March 17, 2010, at 12:50 p.m., revealed that the client required the above observed items during meals and should be fed. Record review on March 17, 2010, at approximately 5:17 p.m., revealed that Client #1's nutritional assessment dated October 12, 2009, recommended a right handled curved spoon, high sided plate, and dycem mat. Additional record review on the same date and time revealed Client #1's nutritional quarterly dated January 2, 2010, recommended that a "nosey cup" be used to minimize spillage during the meal. The assessment further stated, "she is an independent feeder with staff supervision." Staff should set the meal in front of the her and encourage her to eat by putting the spoon in her hand and verbally cue her to eat. Interview with the qualified mental retardation professional (QMRP) on March 19, 2010, at approximately 11:00 a.m., revealed that he completed day program observations earlier this year. During those observations, the QMRP had indicated that the day program staff were not implementing Client #1's mealtime protocol.	W 12	The facility nurse reported to client #1's day program, and inserviced the staff on client #1's mealtime adaptive equipment, and mealtime protocol. 3-19-10 The day program was provided with all of client #1,s mealtime adaptive equipment. The facility nurse went to inservice the day program staff again on 4-15-10 Refer to attachment #1. In the future, the facility management will ensure that client #1 uses similar mealtime adaptive equipment at the facility as well as at the day program; in addition, the QIDP is visiting the day program on an going basis during lunch time to ensure that client #1 is provided with the appropriate mealtime adaptive equipment..	

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W 120	Continued From page 2 Interview with the licensed practical nurse on March 19, 2010, at approximately 1:00 p.m., revealed that he sent a copy of the nutritional assessment to the day program nurse in January 2010. Record verification on March 19, 2010, at approximately 1:30 p.m., revealed documentation from the day program nurse that they received Client #1's nutritional assessment and feeding guidelines. II. The facility failed to ensure that staff working with Client #1 at her day program provided the appropriate level of assistance during her meal. Lunch observations were observed at Client #1's day program on March 17, 2010, at 12:50 p.m. The day program staff was observed feeding the client, using hand over hand techniques. An elevated plate riser, a regular plate, a built up handle spoon and a styrofoam cup were used during the meal. The plate was observed sliding on the elevated plate riser., Interview with the day program staff on March 17, 2010, at approximately 1:20 p.m., revealed that Client #1 required hand over hand assistance to eat her meals. Record review on March 17, 2010, at approximately 5:17 p.m., revealed Client #1's nutritional assessment dated October 12, 2009, indicated that the client was an independent "feeder" with staff supervision. The staff should set the meal in front of the [the client] and encourage [the client] to eat, by putting the spoon in her hand and verbally cueing [the client] to eat. Interview with the QMRP on March 19, 2010, at approximately 11:00 a.m., revealed that the day	W 120	The facility nurse reported to client #1's day program, and inserviced the staff on client #1's mealtime adaptive equipment, and mealtime protocol. 3-19-10 The day program was provided with all of client #1,s mealtime adaptive equipment. The facility nurse went to inservice the day program staff again on 4-15-10 Refer to attachment #1. In the future, the facility management will ensure that client #1 uses similar mealtime adaptive equipment at the facility as well as at the day program; in addition, the QIDP is visiting the day program on an going basis during lunch time to ensure that client #1 is provided with the appropriate mealtime adaptive equipment..	

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W 120	Continued From page 3 program was informed "earlier in the year" that staff were not implementing Client #1's mealtime protocol.	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, facility failed to establish a system that would ensure clients and legal guardians were informed of the risks and benefits of restrictive programs and supports, for one of the three clients in the sample. (Client #2) The finding includes: The facility failed to provide evidence that informed consent was obtained from Client #2 and/or court appointed legal guardian for sedation given during medical appointments as evidenced below: During the entrance conference on March 17, 2010, beginning at 9:00 a.m., licensed practical nurse (LPN), acting qualified mental retardation professional (QMRP) and residential manager (RM) indicated that the client had a "very involved family" member to assist the client in making health care decisions.	W 124	It is the policy of RCM to obtain informed consent from family members, or legal guardians for sedations prior to the medical appointments. In reference to the sedation for podiatry appointment on December 21, 2010, client #1's mother could not report to the facility due to the increment weather, but gave a verbal consent over the phone. The consent form was signed by the mother in later days when the weather cleared out. Client #2's mother signed the informed consent on 12-24-09 Refer to attachment # 2 In the future, the nursing staff will ensure that informed consents are obtained from family members or legal guardians, and that the risks involved with treatment are explained to them.	

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W 124	Continued From page 4 Review of Client #2's medical records on March 18, 2010, at 12:20 p.m., revealed a telephone order for Ativan 2 mg, 30 minutes prior to a December 21, 2009, podiatry appointment. Review of Client #2's Psychological Assessment dated November 30, 2009, on March 18, 2010, at 2:20 p.m., revealed that the client was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of the client's record failed to provide evidence that written informed consent had been obtained for the use of the sedatives. At the time of the survey, the facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client and/or family member.	W 124	It is the policy of RCM to obtain informed consent from family members, or legal guardians for sedations prior to the medical appointments. In reference to the sedation for podiatry appointment on December 21, 2010, client #1's mother could not report to the facility due to the increment weather, but gave a verbal consent over the phone. The consent form was signed by the mother in later days when the weather cleared out. Client #2's mother signed the informed consent on 12-24-09 Refer to attachment # 2 In the future, the nursing staff will ensure that informed consents are obtained from family members or legal guardians, and that the risks involved with treatment are explained to them.	
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained to implement a client's behavior management plan, for one of three clients included in the sample. (Client #2) The finding includes: During medication observation on March 17, 2010, at approximately 7:10 a.m., Client #2 was observed vocalizing loudly, fidgeting, toying with his clothing and striking a desk several times.	W 193		

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W 193	Continued From page 5 The Licensed Practical Nurse (LPN) made no attempt to redirect the behaviors. During a face to face interview with the LPN on March 17, 2010, at approximately 7:20 a.m., revealed Client #2 had never exhibited any targeted behaviors prior to medication administration. Review of Client #2's behavior support plan (BSP) dated on December 13, 2010, at approximately 8:10 a.m., revealed Client #2's listed "physical aggression" and " fidgeting" (toying with clothing) as two of his targeted maladaptive behaviors. The BSP revealed a note that stated if the client engages in physical aggression be prepared to react promptly and appropriately and use verbal redirection. The facility failed to ensure nursing staff was effectively trained specifically on Client #2's behavior management plan.	W 193	All nurses working with client #2 were inserviced on client #2 Behavior Support Plan by the Incident Management Coordinator who was the acting QIDP Refer to attachment #3 In the future, the facility management will ensure that all nurses working with client #2 are trained on his Behavior Support Plan.	3-21-10
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure continuous active treatment, for one of the three clients in the	W 249		

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W 249	Continued From page 6 sample. (Client #2) The finding includes: The facility staff failed to implement Client #2's communication Individual Program Plan (IPP). Observations on March 17, 2010, at 4:05 p.m., staff was heard asking, "[Client #2], where do you wanted to go on your outing this evening." The client did not respond. Several minutes later, the direct care staff was observed assisting the client to the van. Upon the client's return, the staff revealed that the client went to the local park. Review of Client #2's IPP dated December 11, 2009, on March 18, 2010, 2:00 p.m., revealed a program objective which stated, "[the client] will improve his functional communication by showing like/dislike system through tactile stimuli with eventual development and expansion to yes/no system. Interview with the qualified mental retardation professional (QMRP) on March 19, 2010, at approximately 11:10 a.m., indicated that the client has an adaptive communication device. The device was revealed at that time. Further interview revealed that the client should select a desired outing (i.e., park, store, restaurant, etc.)There was no evidence that the staff implemented Client #2's communication goal.	W 249	All staff were trained on client #2's Communication goal. 3-22-10 In addition, a new communication assistive devise (Go talk one) was ordered on 3-25-10 and delivered on 3-29-10 Refer to attachment #4 (a) and 4 (b) In the future, the QIDP will ensure that Client#2's communication goal is implemented as written.	
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has	W 255		

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W 255	Continued From page 7 successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to provide evidence that Individual Program Plans (IPP)s were reviewed and revised once the client had successfully completed an objective, for one of the three clients included in the sample. (Client #3) The findings include: The QMRP failed to revise Client #3's IPP once she met the established criteria. During medication observations on March 18, 2010, at 7:20 a.m., the licensed practical nurse (LPN) was observed preparing Client #3's medications and spoon feeding the client her medications in applesauce. The client was then observed retrieving the cup of water from the nurse and swallowing the medications. Interview with the LPN, after the medication administration, revealed that Client #3 participates in a self medication program. The client was required to get the cup of water from the nurse. Review of Client #3's IPP dated September 11, 2009, on March 10, 2010, at 12:30 p.m., revealed a program objective which stated, "[the client] will take the cup of water from the nurse and swallow her med with it on 20/30 consecutive recorded trials." Review of the data collection sheets from	W 255	Client #3's medication skills IPP was revised by the nurse and QIDP on 4-1-10 Refer to attachment # 5 In the future, the nurse/QIDP will ensure that Client #3's program goal is revised as she makes progress. Client #3's medication skills IPP was revised by the nurse and QIDP on 4-1-10 Refer to attachment # 5 In the future, the nurse/QIDP will ensure that Client #3's program goal is revised as she makes progress.	

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W 255	Continued From page 8 August 2009, through February 2010, revealed that the client was independent on all trials recorded.	W 255		
W 261	483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on interview and review of the Human Rights Committee (HRC) minutes, the facility failed to ensure that persons with no ownership or controlling interest in the facility consistently participated on the committee, for one of the three clients included in the sample. (Client #2) The finding includes: During the entrance conference on March 17, 2010, beginning at 9:00 a.m., the acting qualified mental retarded professional (QMRP), licensed practical nurse (LPN) and the residential manager (RM) indicated that Client #2 required sedation prior to an EEG appointment. It was further indicated that Client #2 had a very involved family member, who was willing to sign medical consents. Review of Client #2's physician orders on March 18, 2010, at 12:20 p.m., verified that sedation (Ativan 2 mg) was ordered to be administered	W 261	It is the policy of RCM to have Community Representatives, as members of the HRC; however, on February 19, 2009, only one advocate did attend the meeting, and happened to be one of RCM's individual's mother. Refer to attachment #6. Many efforts have been made to ensure that review of the facility's HRC include persons with no ownership or controlling interest in the facility. This is an ongoing process. Refer to attachment #6 (current HRC signature Sheets).	

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W 261	Continued From page 9 prior to an EEG laboratory study was scheduled for February 19, 2010. Review of the Human Rights Committee (HRC) meeting minutes was conducted on March 18, 2010, at 3:30 p.m. According to the HRC minutes dated February 1, 2009, Client #2's sedation for an EEG laboratory study was scheduled for the February 19, 2009, was reviewed and approved. Further review of the corresponding signature sheet attached to the minutes failed to evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility. This was acknowledged through interview with the QMRP, March 19, 2010, at approximately 10:00 a.m.	W 261	It is the policy of RCM to have Community Representatives, as members of the HRC; however, on February 19, 2009, only one advocate did attend the meeting, and happened to be one of RCM's individual's mother. Refer to attachment #6 Many efforts have been made to ensure that review of the facility's HRC include persons with no ownership or controlling interest in the facility. This is an ongoing process. Refer to attachment #6 (current HRC signature Sheets).	
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely comprehensive dental treatment services for the maintenance of dental health, for one of the three clients included in the sample. (Client #3) The finding includes: Review of Client #3's medical record on March 19, 2010, beginning at 9:30 a.m., revealed a dental consultation form dated September 8, 2009. The dentist noted that the client had	W 356	Several call s were made to the dentist's office to verify the status of the scaling approval by Medicaid; the follow-up appointment is Scheduled for 4-27-10 See attached consultation form. In the future, the facility will ensure that the individuals are provided with the dental treatment on a timely manner.	

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W 356	Continued From page 10 moderate to heavy calculus deposits and needed scaling. Further review revealed an additional dental consultation form dated November 18, 2009. The consultation form revealed moderate to heavy calculus deposits and recommended scaling on the next visit. Interview with the licensed practical nurse (LPN) on March 19, 2010, at approximately 10:00 a.m., revealed that the client needed preauthorization prior to returning to the dentist office for scaling. At the time of the survey, the facility failed to ensure Client #3 received timely dental services (scaling).	W 356	Several call s were made to the dentist's office to verify the status of the scaling approval by Medicaid; the follow-up appointment is Scheduled for 4-27-10 See attached consultation form. In the future, the facility will ensure that the individuals are provided with the dental treatment on a timely manner.	
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain in good repair clients wheelchair and shower chair for safety, for three of the three clients included in the sample. (Clients #1, #3 and #4) The findings include: 1. The facility failed to maintain in good repair Client #3's wheelchair. On March 17, 2010, at 7:50 a.m., Client #3 was observed in a wheelchair. The left anti-tipper was missing. Interview with the direct care staff	W 436	The vendor was contacted by the facility LPN, and 719-A form was submitted on 3-25-10 Client #3's wheelchair will be assessed 4-19-10 Refer to attachment # 7 In the future, the facility will ensure that all of the individuals' durable medical equipment are always in good repair condition.	

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W 436	Continued From page 11 revealed that they were not aware of the missing anti-tipper. Interview with the license practical nurse (LPN) on March 17, 2010, at approximately 8:30 a.m., indicated that he was also not aware. Although the wheelchair distributor was at the facility within the past two weeks, making repair to Client #3's wheelchair. There was no evidence that the wheelchair was assessed for the replacement of the safety feature. 2. The facility failed to ensure that the adaptive shower chair was safe for clients use, for three of the six five clients residing in the facility. (Clients #1, #3, and #4) On March 17, 2010, at 8:00 a.m., Clients #1, and #3 were observed in wheelchairs and Client #4 was observed using a roller walker. During the environmental inspection on March 19, 2010, at beginning at 3:26 p.m., a shower chair was observed in the bathroom shower. The shower chair's seatbelt did not have a latch to hook the seatbelt in place. The acting qualified mental retardation (QMRP) and LPN, during the environmental inspection confirmed that the seatbelt was broken. The LPN indicated that he would order a new seatbelt.	W 436	The vendor was contacted by the facility LPN, and 719-A form was submitted on 3-25-10 Client #3's wheelchair will be assessed 4-19-10 Refer to attachment # 7 In the future, the facility will ensure that all of the individuals' durable medical equipment are always in good repair condition. The vendor was contacted by the facility LPN to assess the bathroom shower chair. The shower chair will be assessed on 4-19-10 719-A was submitted for the replacement of the old chair by a new one. Refer to attachment #7 In the future, the facility management will ensure that all of the individuals' durable medical equipment are always in good repair.	

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R 000	INITIAL COMMENTS A licensure survey was conducted from March 17, 2010 through March 19, 2010. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a population of four female and two male residents with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and two day programs, interviews with staff, and the review of clinical and administrative records including incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of personnel records, the GHMRP ensured criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check, for all but one out of the eleven staff employed. (Staff #6) The finding includes: On March 19, 2010, beginning at 2:45 p.m., review of personnel records revealed that she began employment in June 2008. He had worked in the Maryland from November 2006 through April 2008. There was no evidence,	R 125		

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R 125	Continued From page 1 however, that a background check had been obtained for that jurisdiction prior to her employment.	R 125	Staff # 6's background check record is currently on file. 4-10-10 In the future, the provider will ensure that all personnel background records are on file, and provided upon request. Refer to attachment # 9	

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I 000	INITIAL COMMENTS A licensure survey was conducted from March 17, 2010 through March 19, 2010. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a population of four female and two male residents with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and two day programs, interviews with staff, and the review of clinical and administrative records including incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the Group Home for the Mentally Retarded (GHMRP) failed to ensure the interior of the GHMRP was maintained in a clean, orderly, attractive, and sanitary manner, for six of six residents residing in the facility. (Residents #1, #2, #3, #4, #5 and #6) The findings include: An environmental inspection conducted on March 19, 2010, beginning at 3:26 p.m. revealed the following: 1. The gutter on right back side of the house was observed pulled from the top of the house.	I 090	The gutter was repaired on 3-20-10 In the future, the facility will ensure that the facility gutters are in a good repair condition.	

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I 090	Continued From page 1 2. The handicapped bathroom shower head holder was broken.	I 090	The handicapped bathroom shower head was replaced on In the future, the facility management will ensure that all of the adaptive equipment are in a good repair condition.	3-20-10
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to store poisons and caustic agents in a locked cabinet and/or out of direct reach of each resident, for six of the six residents residing in the facility. (Residents #1, #2, #3, #4, #5 and #6) The finding includes: During the environmental walk-thru on March 19, 2010, beginning at 3:26 p.m., caustic agents (i.e., all purpose cleaner, bleach, and bathroom cleaners) were observed being stored openly underneath the residents' bathroom. The residents were observed to use the bathroom several times prior to the environmental walk-thru. The unsecured caustic agents were confirmed with the house manager on the same day, during the environmental walk-thru.	I 095	All staff were trained on chapter 35 with the emphasis on the securing of the caustic agents. Refer to attachment # 8 In the future, the facility management will ensure that all of the caustic agents are stored in a locked cabinet.	3-22-10
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by:	I 203		

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I 203	Continued From page 2 Based on interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP), failed to have on file for review, current job descriptions for all employees, for two out of eleven staff. (Staff #2 and #6) The finding includes: Interview with the qualified mental retardation professional (QMRP) and review of the GHMRP's personnel files conducted on March 19, 2010, beginning at 2:45 p.m., revealed the GHMRP failed to provide evidence that the facility discussed the contents of job descriptions with all staff. It should be noted that the presented records did not include a job descriptions for Staff #2 and #6.	I 203	It is RCM policy that all staff have job descriptions on file. Currently staff #2 and 6's job descriptions are on file. Refer to attachment # 9 In the future, the personnel department will ensure that that all staff jobs descriptions are on file, and available upon request.	3-22-10
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP), failed to ensure each staff and consultant had a current health certificate, for the qualified mental retardation professional (QMRP), three of the thirteen staff and one of the twelve consultants. The finding includes:	I 206		

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I 206	Continued From page 3 Interview with the QMRP and review of the personnel records on March 19, 2010, beginning at 2:45 p.m., revealed the GHMRP failed to provide evidence that current health certificates were on file for the QMRP, one of the thirteen staff (Staff #4, #5 and #7) and one of the twelve consultants (Social Worker).	I 206	RCM policy that all staff have current Health certificates on file. Currently the QIDP and staff #4, 5, and 7's Health certificates are current and on file. 4-1-10 Refer to attachment # 11 In the future, the personnel department will ensure that that all staff records are current, and available upon request.	
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to have on file for review current training in cardiopulmonary resuscitation (CPR), for three of the eleven staff and current training in first aid, for five of the eleven staff. The finding includes: Review of the personnel and training records on March 19, 2010, beginning at 2:45 p.m., revealed the GHMRP failed to provide documentation of staff training in CPR, for three of the eleven staff and current training in first aid, for five of the eleven staff.	I 227	RCM policy that all staff be trained on CPR and first aid. 4-1-10 Attachment #11 In the future, the personnel department will ensure that that all staff records are current, and available upon request.	
I 229	3510.5(f) STAFF TRAINING	I 229		

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I 229	Continued From page 4 Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, revealed the facility's nursing staff failed to demonstrate competency in the implementation of the Behavior Support Plan (BSP), for one of three residents included in the sample. (Resident #2) The finding includes: During medication observation on March 17, 2010, at approximately 7:10 a.m., Resident #2 was observed vocalizing loudly, fidgeting, toying with his clothing and striking a desk several times. The licensed practical nurse (LPN) made no attempt to redirect the behaviors. During a face to face interview with the LPN on March 17, 2010, at approximately 7:20 a.m., revealed Resident #2 had never exhibited any targeted behaviors prior to medication administration. Review of Resident #2's behavior support plan (BSP) dated on December 13, 2010, at approximately 8:10 a.m., revealed Resident #2's listed "physical aggression" and " fidgeting" (toying with clothing) as two of his targeted maladaptive behaviors. The BSP revealed a note that stated if the resident engages in physical aggression be prepared to react promptly and	I 229	All nurses were inserviced by the Incident Management Coordinator who was the Acting QIDP on client #2's Behavior Support Plan Refer to attachment #3 In the future, the facility will ensure that all nurses are trained on client #2's Behavior Support Plan. All nurses were inserviced by the Incident Management Coordinator who was the Acting QIDP on client #2's Behavior Support Plan Refer to attachment #3 In the future, the facility will ensure that all nurses are trained on client #2's Behavior Support Plan.	3-21-10 3-21-10

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I 229	Continued From page 5 appropriately and use verbal redirection. The facility failed to ensure nursing staff was effectively trained specifically on Resident #2's behavior management plan.	I 229		
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP), failed to ensure entries in each client's record were signed, for one of the three residents in the sample. (Resident #1) The finding include: On March 17, 2010, at approximately 8:10 a.m., interview with the licensed practical nurse revealed that Resident #1 had been admitted to the facility in October 2009 (approximately six months ago). On March 18, 2010, at 11:23 a.m., review of Resident #1's habilitation record revealed a functional assessment. The assessment was dated October 12, 2009 but not signed by the person completing the assessment.	I 291	The functional assessment was completed by The QIDP who left the Provider in December 2009; however, the acting QIDP did review the Functional assessment, and signed off on it. 3-22-10 Refer to attachment # 12 In the future, the facility management will ensure that all of the assessments are completed, and signed upon completion.	
I 405	3520.7 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers, including both public and private agencies and individual practitioners.	I 405		

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I 405	Continued From page 6 This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure professional services had been provided in accordance with each resident's needs, for one of the three residents included in the sample. (Resident #1) The findins include: I. The facility failed to ensure that staff working with Resident #1 at her day program were using the recommended adaptive feeding equipment. During mealtime observations on March 17, 2010, at 7:30 a.m., 4:00 p.m., and 7:10 p.m., staff was observed putting spoonfuls of food on the Resident #1's spoon and handing it to the resident. The resident was observed putting the food into her mouth, after verbal cueing. The resident used a right handled curved spoon, high side plate, dycem mat and nosey cup, to assist with her meal. Lunch observations were observed at Resident #1's day program on March 17, 2010, at 12:50 p.m. The day program staff was observed feeding the resident, using hand over hand techniques. An elevated plate riser, a regular plate, a built up hand spoon and a styrofoam cup were used during the meal. The plate was observed siding on the the elevated plate riser. Interview with the day program staff on March 17, 2010, at 12:50 p.m., revealed that the resident required the above observed items during meals and should be fed. Record review on March 17, 2010, at	I 405	The facility nurse reported to client #1's day program, and inserviced the staff on client #1's mealtime adaptive equipment, and mealtime protocol. 3-19-10 The day program was provided with all of client #1,s mealtime adaptive equipment. The facility nurse went to inservice the day program staff again on 4-15-10 Refer to attachment #1. In the future, the facility management will ensure that client #1 uses similar mealtime adaptive equipment at the facility as well as at the day program; in addition, the QIDP is visiting the day program on an going basis during lunch time to ensure that client #1 is provided with the appropriate mealtime adaptive equipment..	

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I 405	Continued From page 7 approximately 5:17 p.m., revealed that Resident #1's nutritional assessment dated October 12, 2009, recommended a right handled curved spoon, high sided plate, and dycem mat. Additional record review on the same date and time revealed Resident #1's nutritional quarterly dated January 2, 2010, recommended that a "nosey cup" be used to minimize spillage during the meal. The assessment further stated, "she is an independent feeder with staff supervision." Staff should set the meal in front of the her and encourage her to eat by putting the spoon in her hand and verbally cue her to eat. Interview with the qualified mental retardation professional (QMRP) on March 19, 2010, at approximately 11:00 a.m., revealed that he completed day program observations earlier this year. During those observations, the QMRP had indicated that the day program staff were not implementing Resident #1's mealtime protocol. Interview with the licensed practical nurse on March 19, 2010, at approximately 1:00 p.m., revealed that he sent a copy of the nutritional assessment to the day program nurse in January 2010. Record verification on March 19, 2010, at approximately 1:30 p.m., revealed documentation from the day program nurse that they received Resident #1's nutritional assessment and feeding guidelines. II. The facility failed to ensure that staff working with Resident #1 at her day program provided the appropriate level of assistance during her meal. Lunch observations were observed at Resident #1's day program on March 17, 2010, at 12:50 p.m. The day program staff was observed feeding the resident, using hand over hand	I 405	The facility nurse reported to client #1's day program, and inserviced the staff on client #1's mealtime adaptive equipment, and mealtime protocol. 3-19-10 The day program was provided with all of client #1,s mealtime adaptive equipment. The facility nurse went to inservice the day program staff again on 4-15-10 Refer to attachment #1. In the future, the facility management will ensure that client #1 uses similar mealtime adaptive equipment at the facility as well as at the day program; in addition, the QIDP is visiting the day program on an going basis during lunch time to ensure that client #1 is provided with the appropriate mealtime adaptive equipment..	

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I 405	Continued From page 8 techniques. An elevated plate riser, a regular plate, a built up handle spoon and a styrofoam cup were used during the meal. The plate was observed sliding on the elevated plate riser. Interview with the day program staff on March 17, 2010, at approximately 1:20 p.m., revealed that Resident #1 required hand over hand assistance to eat her meals. Record review on March 17, 2010, at approximately 5:17 p.m., revealed Resident #1's nutritional assessment dated October 12, 2009, indicated that the resident was an independent "feeder" with staff supervision. The staff should set the meal in front of the [the resident] and encourage [the resident] to eat, by putting the spoon in her hand and verbally cueing [the resident] to eat. Interview with the QMRP on March 19, 2010, at approximately 11:00 a.m., revealed that the day program was informed "earlier in the year" that staff were not implementing Resident #1's mealtime protocol.	I 405	The facility nurse reported to client #1's day program, and inserviced the staff on client #1's mealtime adaptive equipment, and mealtime protocol. 3-19-10 The day program was provided with all of client #1,s mealtime adaptive equipment. The facility nurse went to inservice the day program staff again on 4-15-10 Refer to attachment #1. In the future, the facility management will ensure that client #1 uses similar mealtime adaptive equipment at the facility as well as at the day program; in addition, the QIDP is visiting the day program on an going basis during lunch time to ensure that client #1 is provided with the appropriate mealtime adaptive equipment..	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure habilitation, training and assistance were provided to its residents in accordance with their Individual Habilitation Plan(s), for one of the three residents included in the sample. (Resident #2)	I 422		

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I 422	Continued From page 9 The finding includes: The facility staff failed to implement Resident #2's communication Individual Program Plan (IPP). Observations on March 17, 2010, at 4:05 p.m., staff was heard asking, "[Resident #2], where do you wanted to go on your outing this evening." The resident did not respond. Several minutes later, the direct care staff was observed assisting the resident to the van. Upon the resident's return, the staff revealed that the resident went to the local park. Review of Resident #2's IPP dated December 11, 2009, on March 18, 2010, 2:00 p.m., revealed a program objective which stated, "[the resident] will improve his functional communication by showing like/dislike system through tactile stimuli with eventual development and expansion to yes/no system. Interview with the qualified mental retardation professional (QMRP) on March 19, 2010, at approximately 11:10 a.m., indicated that the Resident #2 has an adaptive communication device. The device was revealed at that time. Further interview revealed that the resident should select the desired outings (i.e., park, store, restaurant, etc.). There was no evidence that the staff implemented Resident #2's communication goal.	I 422	The functional assessment was completed by The QIDP who left the provider in December 2009; however, the acting QIDP did review the Functional assessment, and signed off on it. 3-22-10 Refer to attachment # 12 In the future, the facility management will ensure that all of the assessments are completed, and signed upon completion. The functional assessment was completed by The QIDP who left the provider in December 2009; however, the acting QIDP did review the Functional assessment, and signed off on it. 3-22-10 Refer to attachment # 8 In the future, the facility management will ensure that all of the assessments are completed, and signed upon completion,	
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client:	I 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0173	A. BUILDING _____ B. WING _____	03/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	1318 45TH PLACE, NE WASHINGTON, DC 20019

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I 424	Continued From page 10 (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Based on staff interviews and record review, the Group Home for the Mentally Retarded Persons (GHMRP's) Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the resident had successfully completed an objective identified in the IPP, for two of the three residents in the sample. (Residents #2 and #3) The finding includes: 1. The QMRP failed to revise Resident #2's IPP once he met the established criteria. a. On March 18, 2010, at 3:50 p.m., direct care staff was observed providing hand over hand assistance to Resident #2 with washing his hands. Interview with the staff on the same day, at approximately 4:05 p.m., indicated that he required assistance. Resident #2's IPP dated December 13, 2009, was reviewed on March 18, 2010, at 2:10 p.m. The resident had a program objective which stated, "[the resident] will wash his hands before and after meals with hand over hand assistance from staff on 80% of the trials per month for three consecutive months". Record verification of the QMRP monthly notes dated from September 2009, through February 2010, indicated that the resident achieved the established criteria since November 2009. At the time of the survey, the QMRP failed to revise Resident #2's program objective once he	I 424	Client #2's hand washing program objective is being revised, and the change in criteria indicates the progress made. Criteria revised to 75% physical assistance 3-30-10 Refer to attachment #13. In the future, the QIDP will ensure that the goals are revised once the individual meets the criteria.	

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I 424	Continued From page 11 met the established criteria. There was no evidence that the QMRP revised the program (hand washing). 2. The QMRP failed to revise Resident #3's IPP once she met the established criteria. During medication observations on March 18, 2010, at 7:20 a.m., the licensed practical nurse (LPN) was observed preparing Resident #3's medications and spoon feeding the client her medications in applesauce. The resident was then observed retrieving the cup of water from the nurse and swallowing the medications. Interview with the LPN, after the medication administration, revealed that Resident #3 participate in a self medication program. The resident was required to get the cup of water from the nurse. Review of Resident #3's IPP dated September 11, 2009, on March 10, 2010, at 12:30 p.m., revealed a program objective which stated, "[the resident] will take the cup of water from the nurse and swallow her med with it on 20/30 consecutive recorded trials." Review of the data collection sheets from August 2009, through February 2010, revealed that the resident was independent on all trials recorded.	I 424	Client #3's medication skills IPP was revised by the nurse and QIDP on 4-1-10 Refer to attachment # 5 In the future, the nurse/QIDP will ensure that the individuals' program goals are revised as they make progress. Client #3's medication skills IPP was revised by the nurse and QIDP on 4-1-10 Refer to attachment # 5 In the future, the nurse/QIDP will ensure that the individuals' program goals are revised as they make progress.	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.	I 500		

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I 500	Continued From page 12 This Statute is not met as evidenced by: Based on observations, interviews and record review, the the Group Home for the Mentally Retardated Persons (GHMRP)failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for one of the three residents of the facility. (Resident #2) The finding includes: The facility failed to provide evidence that informed consent was obtained from Client #2 and/or court appointed legal guardian for sedation given during medical appointments as evidenced below: During the entrance conference on March 17, 2010, beginning at 9:00 a.m., licensed practical nurse (LPN), acting qualified mental retardation professional (QMRP) and residential manager (RM) indicated that the client had very involved family member to assist the client in making health care decisions. Review of Client #2's medical records on March 18, 2010, at 12:20 p.m., revealed a telephone order for Ativan 2 mg, 30 minutes prior to podiatry appointment dated December 21, 2009. Review of Client #2's Psychological Assessment dated November 30, 2009, on March 18, 2010, at 2:20 p.m., revealed that the client was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of the client's record failed to	I 500	It is the policy of RCM to have Community Representatives, as members of the HRC; however, on February 19, 2009, only one advocate did attend the meeting, and happened to be one of RCM's individual's mother. Refer to attachment #6 Many efforts have been made to ensure that review of the facility's HRC include persons with no ownership or controlling interest in the facility. This is an ongoing process. Refer to attachment #6 (current HRC signature Sheets).	3-22-10

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I 500	Continued From page 13 provide evidence that written informed consent had been obtained for the use of the sedative medication. At the time of the survey, the facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client and/or family member representative.	I 500	It is the policy of RCM to have Community Representatives, as members of the HRC; however, on February 19, 2009, only one advocate did attend the meeting, and happened to be one of RCM's individual's mother. Refer to attachment #6. Many efforts have been made to ensure that review of the facility's HRC include persons with no ownership or controlling interest in the facility. This is an ongoing process. Refer to attachment #6 (current HRC signature Sheets).	3-22-10